

SOUTHEAST HEALTH DISTRICT -
TELEDENTISTRY: MEDICAL/DENTAL HISTORY



2025-2026

LEGAL NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

PREFERRED NAME: _____ WHAT TIME IS BEST TO CONTACT YOU: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: (MONTH) _____ (DAY) _____ (YEAR) _____ AGE: _____ GENDER: MALE FEMALE

ARE YOU CURRENTLY PREGNANT: YES NO *IF YES, ESTIMATED DATE OF DELIVERY: _____

PHONE NUMBERS: (CELL) _____ (HOME) _____ May we text you? _____

CURRENT OB PHYSICIAN: (NAME/PHONE) _____ DATE OF LAST VISIT: _____

CURRENT DENTIST & DATE OF LAST VISIT: _____

ETHNIC BACKGROUND: ASIAN BLACK HISPANIC WHITE OTHER/MULTIPLE/UNKNOWN N/A

1. WHAT IS THE SOURCE OF YOUR KITCHEN SINK TAP/COOKING WATER AT HOME? CITY (PUBLIC) WELL WATER
2. DO YOU TAKE ANY MEDICATIONS AND FOR WHAT MEDICAL CONDITIONS? (*IF YES, EXPLAIN) YES NO

3. ARE YOU ALLERGIC OR SENSITIVE TO ANY MEDICATION/FOOD/OTHER? (*IF YES, EXPLAIN) YES NO

4. HAVE YOU EVER HAD PROBLEMS WITH PREVIOUS DENTAL TREATMENT? (*IF YES, EXPLAIN) YES NO

5. HAVE YOU RECENTLY BEEN SUFFERING FROM DENTAL PAIN/PROBLEMS? (*IF YES, EXPLAIN) YES NO

****INSURANCE INFORMATION:** (PLEASE INDICATE THE INSURANCE COMPANY THE PATIENT IS COVERED BY AND CARD NUMBER)

1. *INSURANCE COMPANY NAME: _____ OR NO INSURANCE COVERAGE

2. *MEMBER ID # ON CARD: _____ EFFECTIVE DATE: _____

3. *MEDICAID ID # ON CARD: (IF DIFFERENT) _____

****REFERRING PHP NURSE AND CONTACT NUMBER:** _____

***(SIGNATURE):** _____

****Please check all that apply and sign:**

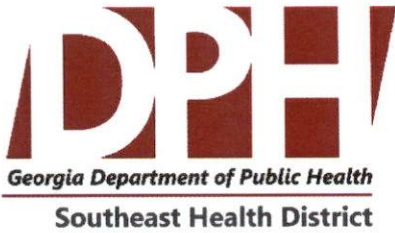
- ANEMIA
- ANXIETY
- ARTIFICIAL JOINTS/VALVES
- ASTHMA
- ATTENTION DEFICIT DISORDER (ADD, ADHD) ***IS MED TAKEN DAILY?** _____
- AUTISM
- BLEEDING EASILY/EXCESSIVELY
- BLOOD DISEASE/DISORDER
- BONE DISORDER
- BRAIN DISORDER
- CANCER ***CURRENT OR REMISSION?**
- CEREBRAL PALSY
- CHEMOTHERAPY TREATMENT
- DIABETES ***TYPE?** _____
- DOWN SYNDROME
- EAR/NOSE/THROAT CONDITION
- EPILEPSY *** WITH SEIZURES?** _____
- FAINTING/DIZZINESS
- FOOD ALLERGIES ***** _____
- EYE DISORDER/GLAUCOMA
- HEADACHES (**FREQUENT**)
- HEART CONDITION (CIRCLE ALL THAT APPLY:) (IRREGULAR HEARTBEAT/ARTIFICIAL HEART VALVE/HEART MURMUR/HEART SURGERY/ OTHER: _____)
- HEPATITIS ***TYPE?** _____
- HIGH BLOOD PRESSURE
- HIV POSITIVE/AIDS
- JAUNDICE
- KIDNEY DISEASE
- LEUKEMIA
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MENTAL DISABILITY ***** _____
- MUSCLE DISORDER
- OPPOSITIONAL DEFIANT DISORDER (ODD) ***IS MED TAKEN DAILY?** _____
- PREGNANT

- PREMEDICATION NEEDED
***EXPLAIN:** _____
- PSYCHIATRIC CARE
***EXPLAIN:** _____
- RASH/HIVES
- RADIATION TREATMENT
- RESPIRATORY/BREATHIING PROBLEM
- RHEUMATIC FEVER
- SCARLET FEVER
- SCOLIOSIS
- SEIZURES (**NOT ASSOC. WITH EPILEPSY**)
***EXPLAIN:** _____
- SICKLE CELL ANEMIA
- SKIN DISEASE
- SPEECH PROBLEM
- SPINA BIFIDA
- STD(s)
- STOMACH DISORDER/INTESTINAL PROBLEMS/ULCERS
- STROKE
- THYROID DISEASE
- TUBERCULOSIS
- TUMORS/GROWTHS

➤ **PLEASE EXPLAIN EACH CONDITION YOU HAVE SELECTED ABOVE AND LIST ANY MEDICATIONS. IT IS VITAL THAT WE HAVE A COMPLETE & ACCURATE MEDICAL HISTORY AS IT HAS A DIRECT IMPACT ON THE PATIENT'S ORAL HEALTH.**

****Initial here if you do NOT have any known health issues (none of the conditions were selected):** _____

***PARENT/GUARDIAN (SIGNATURE):** _____



Southeast Health District

OFFICE OF TELEDENTISTRY
1101 Church Street, Waycross, Georgia 31501
Phone: 912-287-4893 Fax: 912-287-6657

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

CONSENT FOR TELEDENTISTRY SERVICES 2025-2026

* I hereby authorize the Southeast Health District (Ware County Board of Health), affiliated associates, and contracted persons to perform preventive & restorative dental services on myself including, but not limited to: dental screening, exam, radiographs, photographs, prophylaxis (cleaning), fluoride varnish, treatment, sealants, patient education, and case management. Authorizing Dentist: Dr. Jonathan Drawdy, DMD, #DN011282. Referral Dentist: Dr. Page Manus, DMD, #DN010411. 410 Uvalda St. Waycross, GA. 912-283-3542. Hygienist: Kayla Daniels, RDH, #DH010892.

* I authorize the Southeast Health District, affiliated associates, contracted persons to verify and bill insurance, & eligibility by acquiring employment, financial, medical history & other related items deemed necessary for billing purposes. I authorize the Southeast Health District to bill the patient's insurance provider for services provided in the Teledentistry clinics and affiliated associates' offices.

* I authorize and approve the release & disclosure of my medical/dental records maintained by the Southeast Health District, affiliated associates, contracted persons, and other healthcare/dental providers, as requested by a healthcare/dental provider.

* I will contact the Southeast Health District Teledentistry staff with any changes that may occur to my medical/dental history or record while participating in the program at 912-287-4893.

* I am aware of and understand the Ware County Board of Health notice of privacy practices and can view it at <https://www.sehdph.org/services/teledentistry>. My signature signifies that this agreement is valid for one year from the date signed.

* I have read & agree to the terms above & have provided true and accurate information to the best of my knowledge on all forms. I can request a copy of my signed forms at any time.

PATIENT NAME: (PRINT) _____

PATIENT SIGNATURE: (SIGN) _____

TODAY'S DATE: _____/_____/_____

Appling
Atkinson
Bacon
Brantley

Bulloch
Candler
Charlton
Clinch

Coffee
Evans
Jeff Davis
Pierce

Tattnall
Toombs
Ware
Wayne

An Equal Opportunity Employer

Appendix B-2

DMA 635 Form—Attestation of Pregnancy

The **Attestation of Pregnancy** form serves to validate current pregnancy for the purpose of determining whether the member is eligible to obtain certain Medicaid dental service benefits. The member is directed to present completed & signed Attestation of Pregnancy statement to her dentist prior to seeking dental services.

Attestation of Pregnancy

Is currently pregnant & under my care for related services.

Patient Name (please print)

The patient's estimated date of delivery is _____

Please advise of any medical limitations/or restrictions prohibiting the provision of dental care

None

Specify limitations/restrictions (if applicable): _____

I affirm the above information is factual to the best of my knowledge & under penalty of perjury.

Provider Name (please print)

Provider Signature

Signed this _____ day of _____
Date Month Year